

SMALL BUSINESS
GROUP



GroupHealth®

2016
Compare your
plan options

Plans for small businesses

Value-driven
Core network plans
and ALL NEW
choice-driven
Access PPO plans

Harness the power of the right plan.

Welcome to an entirely new suite of plans from Group Health for 2016.

Our biggest, most exciting addition? Access PPO.

It includes more than 600,000 providers and facilities* nationwide, and features the doctors at Group Health Medical Centers who are also at the heart of our value-driven Core network plans. They help make Access PPO one of the largest—if not the largest—PPO available in the state.

These are our most relevant plans ever—with 16 options for groups of every size—and we are committed to making those plans easy for you to administer and for your employees to use.

1 Determine whether you'll offer 1 or 2 plans

TO OFFER 2 PLANS:

- You must have at least 10 employees.
- You can offer any combination of Core and Access PPO plans.
- Groups with 10–24 employees must have at least 3 employees enrolled in each plan.
- Groups with more than 25 employees must have at least 5 employees enrolled in each plan.

2 Decide on your provider network(s)

CORE	ACCESS PPO
Offered by Group Health Cooperative	Offered by Group Health Options, Inc.
Thousands of quality providers and facilities, including: <ul style="list-style-type: none"> • More than 1,000* providers at Group Health Medical Centers • 25 Group Health Medical Centers clinics and pharmacies • More than 9,000 additional network providers and facilities 	Hundreds of thousands of providers and facilities nationwide, including: <ul style="list-style-type: none"> • Group Health Medical Centers clinics and pharmacies • Most providers and designated pharmacies in our service area, including UW Medicine, Swedish Physicians, MultiCare, CHI Franciscan, PeaceHealth, Providence, and more • First Choice Health network providers for Oregon, Alaska, Montana, Idaho, and Washington • First Health Network providers for all other states in the United States • OptumRx network pharmacies

3 Choose your coverage level(s)

All our plans include the same benefits. The main differences are seen in the monthly premiums versus the member's cost shares.

	BRONZE	SILVER	GOLD	PLATINUM
Monthly premium	\$	\$\$	\$\$\$	\$\$\$\$
Cost to members when they get care (Copays, deductible, coinsurance)	\$\$\$\$	\$\$\$	\$\$	\$

PLAN AND BENEFIT DETAILS

Here's a key to the plan names and designations you'll find on the following pages, and an explanation of the benefits you'll find in our plan summary grids.

Employer Contribution plans

These are specific types of health savings account (HSA) plans that allow you to contribute up to \$225 per calendar year to an employee's HSA while keeping the plan within the approved Silver metal level (actuarial range).

Employee Only plans

These include coverage for employees only. Spouses and dependents are not eligible for this coverage, allowing them to seek coverage through Washington Healthplanfinder and receive tax credits, when applicable.

HSA plans

These allow employees to open a personal health savings account (HSA) that can be used to pay for eligible medical expenses. Employees can open an HSA with their own financial institution and the money they deposit in the account is not taxed; they own and control that money.

VisitsPlus plans

These include unlimited office visits for only a copay and are not subject to the deductible.

Ten essential health benefits

A set of benefits that all small group employers must cover: ambulatory patient services, emergency care, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and pediatric services (vision and dental for children through age 18).

2016 Group Health Cooperative plans: Core Provider Network

	BRONZE HSA	SILVER HSA
CALENDAR COSTS		
Annual deductible	\$4,000 Member / \$8,000 Family	\$3,000 Member / \$6,000 Family
Member coinsurance	40%	10%
Out-of-pocket maximum	\$6,450 Member / \$12,900 Family	\$4,500 Member / \$9,000 Family
COMMONLY USED BENEFITS		
	After deductible is met, you pay:	After deductible is met, you pay:
Office visits Primary and specialty care Acupuncture—12 visits PCY Manipulative therapy—10 visits PCY Adult vision exam—1 exam PCY Hardware: \$100 allowance ♦	40%	10%
Prescription drugs Costs per 30-day supply	Generic: 50% Brand: 50% Specialty: 50%	Generic: 20% Brand: 30% Specialty: 50%
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: 45% Brand: 45% Specialty: 50%	Generic: 15% Brand: 25% Specialty: 50%
Urgent care at designated urgent care center	40%	10%
Hospitalization	40%	10%
Emergency services	40%	10%
OTHER ESSENTIAL BENEFITS		
Preventive services	Covered in full ♦	Covered in full ♦
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient/outpatient surgery	Covered in full ♦ 40%	Covered in full ♦ 10%
Laboratory and radiology services	40%	10%
Rehabilitative and habilitative services Inpatient rehabilitation—30 days PCY Outpatient rehabilitation—25 visits PCY DME (durable medical equipment), including prosthetics	40%	10%
Ambulatory outpatient services	40%	10%
Pediatric vision Covered for members up to age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ♦	Covered in full ♦



Dental coverage is required for those up to age 19 and accompanies all Group Health medical plans. See dental flyer for details, as well as information on optional dental coverage for adults and families.

♦ Deductible does not apply | PCY = Per Calendar Year | EC = Employer Contribution up to \$225 PCY | EO = Employee Only

PRIMARY CARE: Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.

SILVER HSA—EC

SILVER

VisitsPlus SILVER

VisitsPlus SILVER—EO

\$3,000 Member / \$6,000 Family	\$1,600 Member / \$3,200 Family	\$1,900 Member / \$3,800 Family	\$1,900 Member / \$3,800 Family
10%	20%	30%	30%
\$4,500 Member / \$9,000 Family	\$6,350 Member / \$12,700 Family	\$6,350 Member / \$12,700 Family	\$6,350 Member / \$12,700 Family
After deductible is met, you pay:	After deductible is met, you pay:	After deductible is met, you pay:	After deductible is met, you pay:
10%	\$20 Primary / \$45 Specialty	Unlimited office visits prior to deductible \$25 Primary ♦ / \$45 Specialty ♦	Unlimited office visits prior to deductible \$25 Primary ♦ / \$45 Specialty ♦
Generic: 20% Brand: 30% Specialty: 50%	Generic: \$10 ♦ Brand: \$40 ♦ Specialty: 50% ♦	Generic: \$10 ♦ Brand: \$40 ♦ Specialty: 50% ♦	Generic: \$10 ♦ Brand: \$40 ♦ Specialty: 50% ♦
Generic: 15% Brand: 25% Specialty: 50%	Generic: \$5 ♦ Brand: \$35 ♦ Specialty: 50% ♦	Generic: \$5 ♦ Brand: \$35 ♦ Specialty: 50% ♦	Generic: \$5 ♦ Brand: \$35 ♦ Specialty: 50% ♦
10%	\$20 Primary	\$25 Primary ♦	\$25 Primary ♦
10%	20%	30%	30%
10%	\$200 + 20%	\$200 + 30%	\$200 + 30%
Covered in full ♦	Covered in full ♦	Covered in full ♦	Covered in full ♦
Covered in full ♦ 10%	Covered in full ♦ 20%	Covered in full ♦ 30%	Covered in full ♦ 30%
10%	20%	30%	30%
10%	20% \$45 Specialty 20%	30% \$45 Specialty ♦ 30%	30% \$45 Specialty ♦ 30%
10%	20%	30%	30%
Covered in full ♦	Covered in full ♦	Covered in full ♦	Covered in full ♦

SPECIALTY CARE: Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pathology • Psychiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

2016 Group Health Cooperative plans: Core Provider Network

GOLD

CALENDAR COSTS

Annual deductible	\$750 Member / \$1,500 Family
Member coinsurance	10%
Out-of-pocket maximum	\$4,500 Member / \$9,000 Family

COMMONLY USED BENEFITS

After deductible is met, you pay:

Office visits Primary and specialty care Acupuncture—12 visits PCY Manipulative therapy—10 visits PCY Adult vision exam—1 exam PCY Hardware: \$100 allowance ♦	\$10 Primary / \$20 Specialty
Prescription drugs Costs per 30-day supply	Generic: \$10 ♦ Brand: \$30 ♦ Specialty: 40% ♦
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: \$5 ♦ Brand: \$25 ♦ Specialty: 40% ♦
Urgent care at designated urgent care center	\$10 Primary
Hospitalization	10%
Emergency services	\$200 + 10%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ♦
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient/outpatient surgery	Covered in full ♦ 10%
Laboratory and radiology services	10%
Rehabilitative and habilitative services Inpatient rehabilitation—30 days PCY Outpatient rehabilitation—25 visits PCY DME (durable medical equipment), including prosthetics	10% \$20 Specialty 10%
Ambulatory outpatient services	10%
Pediatric vision Covered for members up to age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ♦

♦ Deductible does not apply | PCY = Per Calendar Year | EO = Employee Only

PRIMARY CARE: Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.



Dental coverage is required for those up to age 19 and accompanies all Group Health medical plans. See dental flyer for details, as well as information on optional dental coverage for adults and families.

VisitsPlus GOLD

\$500 Member / \$1,000 Family

20%

\$4,500 Member / \$9,000 Family

After deductible is met, you pay:

Unlimited office visits
prior to deductible

\$10 Primary ♦ / \$30 Specialty ♦

Generic: \$10 ♦
Brand: \$30 ♦
Specialty: 40% ♦

Generic: \$5 ♦
Brand: \$25 ♦
Specialty: 40% ♦

\$10 Primary ♦

20%

\$200 + 20%

Covered in full ♦

Covered in full ♦
20%

20%

20%
\$30 Specialty ♦
20%

20%

Covered in full ♦

VisitsPlus GOLD—EO

\$500 Member / \$1,000 Family

20%

\$4,500 Member / \$9,000 Family

After deductible is met, you pay:

Unlimited office visits
prior to deductible

\$10 Primary ♦ / \$30 Specialty ♦

Generic: \$10 ♦
Brand: \$30 ♦
Specialty: 40% ♦

Generic: \$5 ♦
Brand: \$25 ♦
Specialty: 40% ♦

\$10 Primary ♦

20%

\$200 + 20%

Covered in full ♦

Covered in full ♦
20%

20%

20%
\$30 Specialty ♦
20%

20%

Covered in full ♦

VisitsPlus PLATINUM

\$250 Member / \$500 Family

10%

\$2,000 Member / \$4,000 Family

After deductible is met, you pay:

Unlimited office visits
prior to deductible

\$10 Primary ♦ / \$25 Specialty ♦

Generic: \$7 ♦
Brand: \$25 ♦
Specialty: 40% ♦

Generic: \$2 ♦
Brand: \$20 ♦
Specialty: 40% ♦

\$10 Primary ♦

10%

\$200 + 10%

Covered in full ♦

Covered in full ♦
10%

10%

10%
\$25 Specialty ♦
10%

10%

Covered in full ♦

SPECIALTY CARE: Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pathology • Psychiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

2016 Group Health Options, Inc. plans: Access PPO Provider Network

ACCESS PPO BRONZE HSA

CALENDAR COSTS	In network enhanced	In network standard	Out of network
Annual deductible	\$4,000 Member / \$8,000 Family		\$8,000 Member / \$16,000 Family
Member coinsurance	40%		50%
Out-of-pocket maximum	\$6,450 Member / \$12,900 Family		\$19,350 Member / \$38,700 Family

COMMONLY USED BENEFITS

After deductible is met, you pay:

	In network enhanced	In network standard	Out of network
Office visits Primary and specialty care Acupuncture—12 visits PCY Manipulative therapy—10 visits PCY Adult vision exam—1 exam PCY Hardware: \$100 allowance ♦	30%	40%	50%
Prescription drugs Costs per 30-day supply	Generic: 45% Brand: 45% Specialty: 50%	Generic: 50% Brand: 50% Specialty: 50%	Not covered
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: 45% Brand: 45% Specialty: 50%		Not covered
Urgent care at designated urgent care center	30%	40%	50%
Hospitalization	40%		50%
Emergency services	40%		40%

OTHER ESSENTIAL BENEFITS

	In network enhanced	In network standard	Out of network
Preventive services	Covered in full ♦		50%
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient/outpatient surgery	Covered in full ♦ 40%		50%
Laboratory and radiology services	40%		50%
Rehabilitative and habilitative services Inpatient rehabilitation—30 days PCY Outpatient rehabilitation—25 visits PCY DME (durable medical equipment), including prosthetics	40% 30% 40%	40%	50%
Ambulatory outpatient services	40%		50%
Pediatric vision Covered for members up to age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ♦		Routine eye exam: 50%

♦ Deductible does not apply | PCY = Per Calendar Year | EC = Employer Contribution up to \$225 PCY

PRIMARY CARE: Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.



Dental coverage is required for those up to age 19 and accompanies all Group Health medical plans. See dental flyer for details, as well as information on optional dental coverage for adults and families.

What is an “enhanced” benefit? Access PPO is the only PPO network that gives you in-network access to the quality doctors at Group Health Medical Centers. When you choose these doctors—and other select high-performing Washington providers in the major areas we serve—you’ll enjoy the reduced cost shares seen in the “In network enhanced” column.

ACCESS PPO SILVER HSA

In network enhanced	In network standard	Out of network
\$3,000 Member / \$6,000 Family		\$6,000 Member / \$12,000 Family
20%		50%
\$4,500 Member / \$9,000 Family		\$13,500 Member / \$27,000 Family

After deductible is met, you pay:

10%	20%	50%
Generic: 15% Brand: 25% Specialty: 50%	Generic: 20% Brand: 30% Specialty: 50%	Not covered
Generic: 15% Brand: 25% Specialty: 50%		Not covered
10%	20%	50%
20%		50%
20%		20%

ACCESS PPO SILVER HSA—EC

In network enhanced	In network standard	Out of network
\$3,000 Member / \$6,000 Family		\$6,000 Member / \$12,000 Family
20%		50%
\$4,500 Member / \$9,000 Family		\$13,500 Member / \$27,000 Family

After deductible is met, you pay:

10%	20%	50%
Generic: 15% Brand: 25% Specialty: 50%	Generic: 20% Brand: 30% Specialty: 50%	Not covered
Generic: 15% Brand: 25% Specialty: 50%		Not covered
10%	20%	50%
20%		50%
20%		20%

Covered in full ♦		50%
Covered in full ♦ 20%		50%
20%		50%
20% 10% 20%	20%	50%
20%		50%
Covered in full ♦		Routine eye exam: 50%

Covered in full ♦		50%
Covered in full ♦ 20%		50%
20%		50%
20% 10% 20%	20%	50%
20%		50%
Covered in full ♦		Routine eye exam: 50%

SPECIALTY CARE: Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pathology • Psychiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology

2016 Group Health Options, Inc. plans: Access PPO Provider Network

ACCESS PPO VisitsPlus SILVER

CALENDAR COSTS	In network enhanced	In network standard	Out of network
Annual deductible	\$1,900 Member / \$3,800 Family		\$3,800 Member / \$7,600 Family
Member coinsurance	30%		50%
Out-of-pocket maximum	\$6,350 Member / \$12,700 Family		\$19,050 Member / \$38,100 Family

COMMONLY USED BENEFITS

After deductible is met, you pay:

	Unlimited office visits prior to deductible		
Office visits Primary and specialty care Acupuncture—12 visits PCY Manipulative therapy—10 visits PCY Adult vision exam—1 exam PCY Hardware: \$100 allowance ♦	\$25 Primary ♦ \$45 Specialty ♦	\$35 Primary ♦ \$55 Specialty ♦	50%
Prescription drugs Costs per 30-day supply	Generic: \$10 ♦ Brand: \$40 ♦ Specialty: 50% ♦	Generic: \$15 ♦ Brand: \$45 ♦ Specialty: 50% ♦	Not covered
Mail order prescription drugs Costs per 30-day supply up to a 90-day supply, except specialty	Generic: \$10 ♦ Brand: \$40 ♦ Specialty: 50% ♦		Not covered
Urgent care at designated urgent care center	\$25 Primary ♦	\$35 Primary ♦	50%
Hospitalization	30%		50%
Emergency services	\$200 + 30%		\$200 + 30%

OTHER ESSENTIAL BENEFITS

Preventive services	Covered in full ♦		50%
Maternity Routine outpatient prenatal and postpartum visits Labor and delivery: Hospital inpatient/outpatient surgery	Covered in full ♦ 30%		50%
Laboratory and radiology services	30%		50%
Rehabilitative and habilitative services Inpatient rehabilitation—30 days PCY Outpatient rehabilitation—25 visits PCY DME (durable medical equipment), including prosthetics	30% \$45 Specialty ♦ 30%	30% \$55 Specialty ♦ 30%	50%
Ambulatory outpatient services	30%		50%
Pediatric vision Covered for members up to age 19 1 routine exam per year; 1 pair of lenses and frames PCY or annual supply of contacts in lieu of glasses	Covered in full ♦		Routine eye exam: 50%

♦ Deductible does not apply | PCY = Per Calendar Year

PRIMARY CARE: Acupuncture • Chemical Dependency/Substance Abuse • Chiropractic/Manipulative Therapy • Emergency Medicine (where ER copay doesn't apply) • Family Medicine • Family Planning • Internal Medicine • Mental Health • Midwifery • Naturopathy • Obstetrics/Gynecology • Optometry • Osteopathy • Pediatrics • Urgent Care • Women's Health Care

NOTE: This is an overview of benefits. The contents are not to be accepted or construed as a substitute for the provisions of the medical coverage agreement. Other terms and conditions may apply. A list of excluded services and other limitations can be found in each plan's Summary of Benefits and Coverage document.



Dental coverage is required for those up to age 19 and accompanies all Group Health medical plans. See dental flyer for details, as well as information on optional dental coverage for adults and families.

What is an “enhanced” benefit? Access PPO is the only PPO network that gives you in-network access to the quality doctors at Group Health Medical Centers. When you choose these doctors—and other select high-performing Washington providers in the major areas we serve—you’ll enjoy the reduced cost shares seen in the “In network enhanced” column.

ACCESS PPO VisitsPlus GOLD

In network enhanced	In network standard	Out of network
\$600 Member / \$1,200 Family		\$1,200 Member / \$2,400 Family
20%		50%
\$4,500 Member / \$9,000 Family		\$13,500 Member / \$27,000 Family

After deductible is met, you pay:

Unlimited office visits prior to deductible		
\$10 Primary ♦ \$30 Specialty ♦	\$20 Primary ♦ \$40 Specialty ♦	50%
Generic: \$5 ♦ Brand: \$25 ♦ Specialty: 40% ♦	Generic: \$10 ♦ Brand: \$30 ♦ Specialty: 40% ♦	Not covered
Generic: \$5 ♦ Brand: \$25 ♦ Specialty: 40% ♦		Not covered
\$10 Primary ♦	\$20 Primary ♦	50%
20%		50%
\$200 + 20%		\$200 + 20%

ACCESS PPO VisitsPlus PLATINUM

In network enhanced	In network standard	Out of network
\$250 Member / \$500 Family		\$500 Member / \$1,000 Family
10%		50%
\$2,000 Member / \$4,000 Family		\$6,000 Member / \$12,000 Family

After deductible is met, you pay:

Unlimited office visits prior to deductible		
\$10 Primary ♦ \$25 Specialty ♦	\$20 Primary ♦ \$35 Specialty ♦	50%
Generic: \$5 ♦ Brand: \$15 ♦ Specialty: 40% ♦	Generic: \$10 ♦ Brand: \$20 ♦ Specialty: 40% ♦	Not covered
Generic: \$5 ♦ Brand: \$15 ♦ Specialty: 40% ♦		Not covered
\$10 Primary ♦	\$20 Primary ♦	50%
10%		50%
\$200 + 10%		\$200 + 10%

Covered in full ♦		50%
Covered in full ♦ 20%		50%
20%		50%
20% \$30 Specialty ♦ 20%	20% \$40 Specialty ♦ 20%	50%
20%		50%
Covered in full ♦		Routine eye exam: 50%

Covered in full ♦		50%
Covered in full ♦ 10%		50%
10%		50%
10% \$25 Specialty ♦ 10%	10% \$35 Specialty ♦ 10%	50%
10%		50%
Covered in full ♦		Routine eye exam: 50%

SPECIALTY CARE: Allergy and Immunology • Anesthesiology • Audiology • Cardiology (pediatric and cardiovascular disease) • Chiropractic/Manipulative Therapy • Critical Care Medicine • Dentistry • Dermatology • Endocrinology • Enterostomal Therapy • Gastroenterology • Genetics • Hematology • Hepatology • Infectious Disease • Massage Therapy • Neonatal-Perinatal Medicine • Nephrology • Neurology • Nutrition • Occupational Medicine • Occupational Therapy • Oncology • Ophthalmology • Orthopedics • Otolaryngology (ear, nose, and throat) • Pathology • Physiatry (rehabilitation) • Physical Therapy • Podiatry • Pulmonary Medicine/Disease • Radiology (nuclear medicine, radiation therapy) • Respiratory Therapy • Rheumatology • Speech Therapy • Sports Medicine • General Surgery (all surgical specialties) • Urology



FOR MORE INFORMATION

- Contact your producer
(agent/broker)
- Contact your Group Health
sales representative directly
or call 1-800-542-6312
- Visit ghc.org/sbg



GroupHealth®